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EVALUATION OF A POSITIVE PSYCHOLOGY INTERVENTION FOR HEALTH PROMOTION OF RETIREES

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ABSTRACT. This study aimed to evaluate a Positive Psychology programme for health promotion of retirees, based on evaluation of participants with regard to levels of satisfaction with the programme/group and with the moderator, comprehension and application of contents and maintenance/long-term application of contents. A mixed longitudinal design, with pre-test (T1), post-test (T2), and follow-up (T3 - three months) evaluations was used. 65 retirees answered a programme evaluation questionnaire. Quantitative results indicated higher mean rates for satisfaction with the moderator and programme; and lower rates for the programme length/duration. Qualitative analysis indicated that 77.7% of the sample at T2, and 87.2% at T3 reported having used contents of the programme in their lives. Maintenance of application of contents was observed for empathy, self-care, optimism, gratitude, forgiveness and self-forgiveness. Positive outcomes demonstrate this pattern of intervention for health promotion – based on Positive Psychology and CBT – presents the potential to be applied within public health contexts for the promotion of active aging.

Keywords: Positive psychology; retirement; health intervention.

AVALIAÇÃO DE INTERVENÇÃO PSICOLÓGICA POSITIVA PARA A PROMOÇÃO DE SAÚDE DE APOSENTADOS

RESUMO. Este estudo teve como objetivo avaliar a intervenção psicológica positiva para promoção de saúde de aposentados, a partir da avaliação dos participantes, no que se refere à satisfação com o programa e com o moderador, clareza/compreensão/aplicação dos conteúdos e manutenção da aplicação ao longo de tempo, com delineamento longitudinal misto e avaliação pré (T1), pós-teste (T2) e seguimento (T3 - 03 meses). Participaram 65 aposentados que responderam ao questionário misto de avaliação do programa. Análises quantitativas indicaram maiores médias para satisfação com o programa e com o moderador; e menor média para tempo de duração do programa. Dos 77,7% participantes em T2 e 87,2% em T3 utilizaram nas suas vidas os conteúdos trabalhados no programa. Foi observada manutenção da aplicação dos conteúdos de empatia, autocuidado, otimismo, gratidão, perdão e autoperdão. Resultados positivos demonstram que este modelo de intervenção para promoção de saúde – com base na psicologia positiva e TCC – apresenta potencial para ser aplicado em contextos de saúde pública e promoção de envelhecimento ativo.

Palavras-chave: Psicologia positiva; aposentadoria; intervenção em saúde.

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EVALUACIÓN DE INTERVENCIÓN PSICOLÓGICA POSITIVA PARA PROMOCIÓN DE LA SALUD DE JUBILADOS

RESUMEN. Este estúdio evaluó una intervención psicológica positiva para La promoción de la salud de jubilados, basado em laevaluación de los participantes, encuanto a satisfacción com el programa y com el moderador, claridad/comprensión/aplicación de los contenidos y mantenimiento de La aplicaciónen el tiempo, condiseño longitudinal mixto y evaluación pre (T1), posterior a laprueba (T2) y seguimiento (T3 - tres meses). Participaron 65 jubilados que respondieron los cuestionarios de evaluación del programa. Los análisis cuantitativos indican promedios más altos para satisfacción conel moderador y programa; y más bajo para laduración del programa. 77.7% de los participantes en T2 y 87.2% en T3 usaron en sus vidas los contenidos trabajados em el programa. Se observo mantenimiento de la aplicación de lãs variables empatía, autocuidado, optimismo, gratitud, perdón y autoperdón. Los resultados positivos demuestran que este modelo de intervención presenta potencial de ser aplicado en contextos de salud pública y promoción Del envejecimiento activo.

Palabras clave: Psicología Positiva; jubilados; intervención em salud.

Introduction

Changes in the sociodemographic profile of the Brazilian population following the global trend of population aging with longevity – life expectancy – and reduced birth rates, are among the biggest gains in terms of health in the last century (World Health Organization [WHO], 2015). However, this aging trend poses challenges for the service network for this vulnerable population, due to the lack of public policies, professional qualifications, inputs (material and human resources), and specialized services, overloading the health network, and often, resulting in inappropriate or unavailable services for this portion of the population (Barbosa, Freitas, & Neufeld, 2017).

One of the factors that worsen the quality of life at advanced ages is related to aspects of life and work, given the considerable increase in the number of retirees in the country frequently without resources to better adapt to this stage of life, promote active aging, and overcome possible adversities from the progression of age such as physical and psychological comorbidities (Nalin & França, 2015; Leandro-França & Murta, 2019). Furthermore, especially in Brazil, around a third of retirees are economically active in the country because, despite the national social security program, benefits are unequally distributed, and there is a need to return to the workforce due to economic needs (Wong & Carvalho, 2006). Thus, retirement must be seen not only as the act of stopping working but as a process and new stage of life with challenges for the individual, their family, and the relationship cycle.

Retirement can be perceived as an increase in satisfaction with life, possibilities for (re)discoveries and social bonds, and reconstitution of personal identity for some – in the case of a planned retirement – as well as negative consequences for others, such as higher anxiety, social isolation, reduced standard of living and self-esteem (perceiving oneself inactive), inability to manage free time, lack of meaning in life, depression and even suicide ((Kail & Carr, 2016). Among the factors with great impact on the emotional, mental, and

physical health of retired individuals are aspects related to the loss of the regulatory role that work plays in life, reduction in socioeconomic conditions and social relationships, death of family members, children leaving home, and possible health impairments and comorbidities resulting from aging (Nalin & França, 2015; Leandro-França & Murta, 2019).

A recent practice for health promotion implemented in an international context includes Positive Psychological Interventions (PPIs), which have demonstrated satisfactory results for changing cognitive processes, helping with greater mental flexibility and resilience, and improving well-being and health, both of individuals with a clinical diagnosis (depression), as well as non-clinical diagnosis, which suggests the effectiveness of interventions for reducing depressive symptoms, including at advanced ages (Seligman, Rashid, & Parks, 2006; Stoner, 2019; Sutipan, Intarakamhang, & Macaskill, 2016). This intervention model aims to promote psychological resources (character strengths-virtues) through interventional practices and methods for developing positive thoughts, feelings, and behaviors in the individual, resulting in greater resilience and better health (Sin & Lyubomirsky, 2009). Furthermore, international literature points out that positive perception of mental and physical health is among the most commonly reported predictors for better adjustment to retirement, which highlights the importance of working on these aspects in interventions for this age group (Barbosa, Monteiro, & Murta, 2016).

Among the strengths worked on in PPIs, variables such as gratitude, forgiveness, and optimism have gained space in current programs, with demonstrated effects, not only in preventing psychic pathologies but also in overcoming traumatic events and harmful impacts on physical health (Hendriks, Schotanus-Dijkstra, Hassankhan, de Jong, & Bohlmeijer, 2019). It is worth remembering that optimism is a fundamental variable leading to greater adjustment to retirement (Barbosa et al., 2016). Furthermore, the meaning individuals attribute to life and work and pro-social values are beneficial factors significantly impacting general health. Positive emotions help to alleviate or recover more quickly from psychophysiological effects such as cardiovascular reactivity, inflammatory processes, and immunosuppression, generally aggravated in stressful situations (Ghielen, Van Woerkom, & Christina Meyers, 2017; Kiken & Fredrickson, 2017).

Therefore, proposals to expand the health management model by introducing health promotion practices focused on developing individuals' strengths/potentialities become indispensable. In this way, the use of PPI practices by professionals/clinicians has been increasingly encouraged to work in both individual and group care and for target audiences at risk of developing depression and/or who are relatively elderly (Sin & Lyubomirsky, 20099). Furthermore, data indicate a linear increase in well-being results according to the participant's age group and greater benefits from multicomponent PPIs – which use a combination of practices and work on different outcome variables – compared to a control group or other interventions to promote well-being (Bolier et al., 2013; Sin & Lyubomirsky, 2009).

Although PPIs, based on evidence through structured programs – with empirically based validity – to promote the health of retirees is not yet a recurrent practice in Brazil, in other countries, this model has been used and presented consistent and promising results (Bolier et al., 2013; Sin & Lyubomirsky, 2009). Thus, as health is considered a dynamic, multicausal, and multidimensional process, and taking into account the limited range of multicomponent programs offered nationally for the promotion of strengths-virtues in retired individuals, the Vem Ser Program: Positive Psychology program for health promotion in retirees was developed, implemented and evaluated. The program underwent a pilot study (Durgante, Mezejewski, & Dell'Aglio, 2020), followed by a feasibility study (Durgante,

Navarine, & Dell'Aglio, 2019) and an efficacy trial (Durgante & Dell'Aglio, 2019a; Durgante, Bedin, Lima, & Dell'Aglio, 2020). Quantitative results indicated the main effects of improvement in health indicators (satisfaction with life and resilience) and reduction in symptoms of psychopathology (perceived stress, depression, and anxiety) in the intervention group, in addition to interaction effects for an increase in empathy, reduction in symptoms of depression and anxiety in the experimental group, compared to controls, after the program. Main and interaction effects (reduction in depression and anxiety symptoms) were maintained approximately three months after the end of the program (Durgante et al., 2020).

In this context, this study evaluated the results of the Vem Ser Program, based on the evaluation by the participants, considering the following criteria: a) satisfaction of participants with the program and the moderator; b) clarity and understanding of the contents covered in the program; c) application of the content by participants in their daily lives; d) maintenance/long-term use of the content. A mixed longitudinal study was carried out with participants of the intervention program and pre-test (T1), post-test (T2), and follow-up (T3 - three months after the end of the program) assessments.

Description of the Vem Ser Program

The Vem Ser Program intervenes in different strengths (Values and Self-Care, Optimism, Empathy, Gratitude, Forgiveness, and Meaning of Life and Work) based on a group intervention carried out in six sessions (2h each) weekly, with groups of five to 15 people, totaling 12 face-to-face program hours. This format was created taking into account meta-analysis results on similar interventions applied to adults over 35 years of age (Sin & Lyubomirsky, 2009). The program was theoretically based on Positive Psychology (Seligman et al., 2006; Snyder & Lopes, 2009) and Cognitive-Behavioral Therapy perspectives as a reference for conducting session activities (Knapp & Beck, 2008). The themes and activities of each session of the Program were: 1) Values and self-care: Health Curtograma and preparation of the Self-Care Protocol; 2) Optimism: interpretation of problems (optimistic versus pessimistic attributional style) and Projection of the 'Best Possible Self'; 3) Empathy: collectivism and culture of peace, 'putting yourself in other people's shoes'; 4) Gratitude: preparation of a gratitude list and gratitude diary; 5) Forgiveness: responsibility vs blame, letter of forgiveness; 6) Meaning of life and work: identify personal strengths and future goals. All these aspects are detailed in the Vem Ser Program implementation manual (Durgante & Dell'Aglio, 2019b), which includes more information on conceptual aspects of Positive Psychology and guidelines for implementing the program.

Method

Design

This was a mixed method longitudinal study to evaluate participants' satisfaction with the program and the moderator, the clarity and understanding of the contents, the application of the content by the participants, and the maintenance/long-term application of the contents.

Participants

The convenience sample consisted of 65 adults (Female=84.6%), aged 49-86 years (M=66.52; SD=7.26), from the metropolitan region of Porto Alegre, state of Rio Grande do

Sul, who were distributed among six intervention groups of the program according to schedule availability and participant interest. In total, 54 participants (Female=87%) aged 49-86 years (M=66.37; SD=7.42) completed the assessments after the end of the program, T2 (loss of 16.9%); and 47 participants (Female=85.1%) aged 49-81 years (M=66;SD=7.26) completed follow-up assessments, T3 (27.6% loss). The total loss rate of participants in this study remained lower than that found in similar research conducted in a national context, which was 37.7% (Damásio, Golart, & Koller, 2015). Data from participants who completed T2 and T3 were used for qualitative assessment. The inclusion criteria were: a) being retired, b) being literate, and c) participating in the assessments.

Instruments

To evaluate results, data were collected from descriptive questions and in questionnaire format in T2 (Program Assessment Measure) and descriptive questions in T3 (Descriptive Follow-up Assessment Measure), with the following instruments:

1. Admission Questionnaire (T1): to collect sociodemographic data, aspects related to retirement and health.

2. Program Assessment Measure (T2): To assess participants' satisfaction with the program and the moderator, Clarity and Understanding of the content covered, and Application of learning in real life after the end of the program. This mixed measure contains nine self-report questions on a four-point scale (1 to 5) plus five descriptive questions about the use of the program content, perceived differences in dealing with problems, perceiving the needs of others, health status after participating in the program, and suggestions. The assessment was answered anonymously and applied by other team members (observers), allowing participants to freely express their evaluations and suggestions for the program.

3. Descriptive Follow-up Assessment Measure (T3): Five descriptive questions to assess which program activities/discussions the participants remembered, whether they put into practice anything learned, perception of life regarding difficulties and problems, differences in health after participation, and whether the program helped to better understand the needs or difficulties of others.

Ethical and Data Collection Procedures

The guidelines and standards of Resolution 510/2016 of the National Health Council (Resolução nº 510, 2016) for ethics in research with human beings were followed. The research project was approved by the Research Ethics Committee of the Federal University of Rio Grande do Sul (opinion 1.899.368). The program was publicized in retiree groups, folders, social networks, newspapers, and emails. Interested parties were individually interviewed (30-40min) by two technical team members to verify sociodemographic data and availability to participate in the intervention, in addition to being asked to sign the Informed Consent. Members of the technical team helped with reading and filling out the instruments. After completing the program (T2), participants responded to the Program Assessment Measure, and three months after the end of the program (T3), they responded to the Descriptive Follow-up Assessment Measure. The application of the evaluation protocol and intervention was carried out by different researchers (single-blind) to avoid contamination by the experimenter effect and ensure the reliability of the data obtained (Levitt et al., 2018).

Data Analysis Procedures

Quantitative self-report data on satisfaction with the program and the moderator, clarity and understanding, and application of content obtained in T2 were analyzed using

descriptive statistics, observing the means of the items. The descriptive questions of T2 and T3 were evaluated based on the count/frequency of words (or synonyms) corresponding to the themes/topics defined a priori: participant satisfaction with the program and the moderator, clarity, understanding, and application of the content, and maintenance/long-term effects of the intervention. The analyses were conducted by independent researchers and evaluated by a third researcher – expert checking – fulfilling the consistency criterion for greater validity in qualitative research (Levitt et al., 2018).

Results and Discussion

Regarding the sociodemographic data of the sample, the level of education varied between 44.6%, who had up to high school, and 55.4%, who had education above high school; as for marital status, 41.5% were married or in a stable union, 26.2% divorced/separated, 23.1% widowed and 9.2% were single; type of retirement: 67.7% based on contribution time, 13.8% special retirement, 9.2% due to age or disability; on average, participants worked 28.81 years (SD=9.82), with an average retirement period of 13.14 (SD=11.21); 53.8% were caregivers for someone (parents, spouses, etc.); 50.8% worked after retirement (paid or unpaid); 43.1% lived alone; 30.8% have already received some diagnosis of psychopathology; 27.7% were experiencing grief/bereaved; and only 13.8% participated in a retirement preparation program/training/lecture.

Quantitative assessment in T2

Means and standard deviation of the items regarding satisfaction with the program and the moderator, clarity and understanding, application of content, and the variation in results obtained in T2, are described in Table 1.

Table 1
Means and standard deviations in the items of satisfaction with the program (T2)

Instrument items	Variation	Mean (SD)
In general, how did you feel during the program?	3 - 4	3.87 (0.33)
What is your overall satisfaction with the program?	2 - 4	3.70 (0.53)
What is your assessment of the group facilitator?	2 - 4	3.91 (0.40)
How satisfied are you with the learning in the program?	2 -4	3.70 (0.57)
How satisfied are you with the duration of the sessions?	2 - 4	3.56 (0.60)
How satisfied are you with the session times?	2 - 4	3.67 (0.54)
Was it difficult to participate in all the program sessions?	1 - 4	1.30 (0.60)
Clarity and Understanding	Variation	Mean (SD)
Did you understand the content covered during the sessions?	1 - 4	3.61 (0.59)
Application	Variation	Mean (SD)
How much did you apply the content covered in the program to your daily life?	2 – 4	3.22 (0.53)

SD=Standard deviation

Based on the score given by the participants, the item with the highest score was satisfaction with the group moderator, followed by the positive perception about how the participants felt throughout the sessions, satisfaction with the program as a whole, and also regarding the learning/understanding of the content covered in the program. Another well-evaluated aspect concerns the schedule of the program sessions. It is worth remembering that there was initial effort/care by the program's technical team to implement different intervention groups throughout the year, adopting reversed shifts and alternate weekly days. Furthermore, during the initial interview, data were collected on participants' preferences for a specific period/shift to reduce barriers to participation and encourage greater participant adherence. This may have positively impacted the participants' assessment of whether their possible needs had been met to participate in the program.

On the other hand, items with lower scores relate to perceived difficulties in attending all program sessions and satisfaction with the duration of program sessions. However, the first item had an inverted configuration, so low results indicate that participants did not have any difficulties in attending all program sessions. Regarding the application of the contents in their daily life, the overall average obtained was high (M=3.22 for a score of 2-4) but lower than other items evaluated in T2. Therefore, although it is a brief intervention, there was preparation/processing of the content worked on during the program by the participants, as the use and application of the content in daily life were observed.

Qualitative assessment in T2

In order to deepen the understanding of the quantitative results obtained, Content Analysis (Saldaña, 2009) was conducted on the qualitative data/vignettes brought by the participants. The results were organized into the following categories: satisfaction with the program, satisfaction with the moderator, and application of the content.

Satisfaction with the program

The best-evaluated points relate to how participants felt during the sessions, level of satisfaction, learning from the program/clarity and understanding of the content, and session times. "The memories are of a lot of learning and great interaction with different people" (M.C. 65 years old, Group1-afternoon), "What I remember are the meditation dynamics, the videos that were striking on the themes, and themes such as forgiveness, resilience, and optimism" (M. 49 years old, Group1-afternoon), "All the meetings were very pleasant and interesting, always with some point that caught our attention, which led us to questions and a desire to improve" (T. 70 years old, Group4-morning), "[…] memories [...] the discussions and debates with the supervisor and colleagues. I had the opportunity to see myself from the inside and make a brief analysis of my feelings/emotions. After studying Engineering, returning to university in a very different subject was very good" (R. 66 years old, Group 4-morning). Regarding these aspects, prudence in the empirical rigor for the elaboration of the themes, dynamics, and techniques of the sessions, based on the literature on PPI (Bolier et al., 2013; Ramírez, Ortega, Chamorro, & Colmenero, 2013; Seligman et al., 2006; Sin & Lyubomirsky, 2009) and adapted for use in this context; as well as the care in offering different groups in shifts and alternate days of the week, can be considered strengths in the program's procedures. This flexibility in the intervention can affect the retention rates obtained (Neufeld, Maltoni, Ivatiuk, & Rangé, 2017).

In the objective questions of the instrument, the item with the lowest score regarding satisfaction with the program was related to the short session duration and the demand for

more sessions (longer duration of the program). These data converged with descriptive reports from the participants, such as: “I thought it was good, but it could have been longer” (M.C. 65 years old, Group1-afternoon), “Longer duration and more themes” (B. 59 years old, Group2-morning), “More hours to debate” (M. 55 years old, Group3-afternoon), “Continue the sessions. I loved it” (M. 61 years old, Group5-afternoon), “More courses” (E. 65 years old, Group5-afternoon), “I think the time from 2:30 am to 5 pm is short. It could be from 2:00 pm to 6:00 pm” (I. 70 years old, Group6-afternoon).

However, even though it was suggested to increase the dose (duration time and number of sessions), the duration of the intervention was similar to other interventions for health promotion and disease reduction Bolier et al., 2013; Sin & Lyubomirsky, 2009), and in line with models of Cognitive-Behavioral Group Therapy in a psychoeducational nature, which tend to last four to six weeks (Neufeld et al., 2017). Furthermore, according to the Good-Enough Level (GEL) Model (Owen, Adelson, Budge, Kopta, & Reese, 2014) – for doses of psychological interventions, data indicate that small doses of treatment (six to eight sessions) are related to rapid changes while prolonging therapy tends to result in slow changes or changes that are barely observable in the long term.

Thus, even though a longer session and program duration were suggested, it is understood that it is appropriate to continue studies with the program in the proposed format for implementation in other samples; however, submitted to changes if necessary to adapt the program to different target audiences. Nevertheless, even if there were complaints about the duration, this aspect may implicitly highlight satisfaction with the program, as participants requested its extension due to their positive perception regarding the activities carried out.

Satisfaction with the moderator

The results of the descriptive responses obtained in T2 converge with the quantitative data regarding satisfaction with the group moderator, for example, “Our teacher was great, with an exemplary personality” (E., 81 years old, Group3-afternoon). Similarly, among the main memories of the program (three months after the end), the role of the group moderator was evident as an influencing variable for the integration of participants and the fluidity of the sessions, “[...] the rapport between the participants and the (moderator) (M. 57 years old, Group1-afternoon), “I remember the welcoming, pleasant, relaxed atmosphere and the kindness of the program moderator. She is extremely professional and competent. She knew how to keep the group focused” (I. 82 years old, Group5-afternoon); “I remember the friendly, interesting, and safe environment created. It made us curious to know what would be presented to us. I remember the welcoming manner of the (moderator) and the personal and deep sharing of the group” (A.V. 53 years old, Group5-afternoon); “Competence of the teacher (moderator) and especially her contagious enthusiasm in what she does” (I. 70 years old, Group6-afternoon).

Regarding the role of the group moderator in interventions, this is fundamental to be taken into consideration during the assessment since therapist variables such as empathic ability to establish therapeutic alliance, competence for group management, skills to provide feedback on performances and/or positive reinforcement, motivation, and resourcefulness to manage time and possible conflicts during sessions, tend to directly influence adherence and subsequent success or failure of the treatment (Mônego, 2016).

However, data from a recent review indicate a gap in the national literature on adherence to psychosocial treatment, mainly in interventions in the public health network (Alvarez, Rosendo, & Alchieri, 2016). This reiterates the need for empirical efforts to investigate variables, in addition to those specific to the therapist, that assist in greater

adherence to treatments for this age group of interest. From a greater understanding of participant adherence to specific treatments and, consequently, a favorable prognosis, more effective intervention models with reduced costs should be designed both for the patient and the health network as a whole. In this sense, it is possible to encourage the flow of services and optimization of human and material resources based on consistent literature on treatment adherence.

Furthermore, according to guidelines for evaluating intervention programs (Levitt et al., 2018), future studies with the program should include an evaluation of results with the implementation of the program by different moderators. This allows for a more in-depth analysis of results, and the role of influence of the moderator's social skills and mode of implementation, based on the moderator's integrity/reliability in complying with the program protocol. These aspects remain open for future investigation.

Application of the contents

As for the application of learning in real life, the results were satisfactory. From qualitative data analysis, 42 participants (77.7% of the sample in T2) reported having used one or more of the contents covered in the program in their daily lives. Regarding the maintenance of this learning, that is, if the participants continued to use the learning from the program in their lives three months after the end of the program (T3), 41 participants (87.2% of the sample in T3) reported still use one or more of the contents. The contents most applied after the program (T2 and T3) are illustrated in Table 2.

Table 2

Frequency of content applied in T2 and T3

Content	T2	T3
Empathy	27	24
Self-care/Prudence	19	21
Optimism	12	10
Gratitude	11	11
Forgivenessand self-forgiveness	11	11

The most applied content worked on in the program, being used beyond the context of the intervention, was empathy, both in T2 and T3. According to the reports, this variable seems to have contributed to greater understanding and patience in interpersonal relationships with family members, and perception of the needs of others and themselves. Furthermore, from a greater understanding of what 'empathy' conceptually is and the implication of interpersonal relationships in health, including the concept of 'self-empathy' addressed in the session, mobilization for self-care was observed in the participants' vignettes: "I have managed to be more tolerant, what it's like to put yourself in other people's shoes" (L. 73 years old, Group5-afternoon); "I was attentive to the perception of others, analyzing the real needs or difficulties of others" (M. 61 years old, Group6-afternoon).

In this case, positive side effects from the program (unexpected/unplanned effects) may have arisen, such as, for example, the fact that women can say 'no' and dedicate time to themselves and their self-care, without, however, feeling guilt or remorse (recognition and respect for personal limits/needs): "I learned to say 'no, something that I had a lot of difficulty

with because I was always wanting to help and I kept thinking that people would be hurt" (A.67 years old, Group2 -morning).

Considering that more than 50% of the sample was made up of caregivers (parents, spouses, etc.), and people who worked after retirement, respectively, where more than 40% lived alone and almost 30% were going through bereavement, the issue of self-care is a fundamental topic in programs like this. This may also justify why the program was perceived as useful as social support for those who were bereaved, highlighting the aspect of self-health care: "We took a lot from here. I put it into practice, this is self-knowledge. More time for myself, appreciation for a healthy life, care when choosing food, self-esteem" (E. 71 years old, Group2-afternoon).

However, when working on topics with deep-rooted cultural specificities (knowing how to say 'no', for example), implicit norms about the regulatory role of gender are questioned, challenged, and put up for verification based on empirical evidence about their usefulness or not, about global health (Davis, 2016). Therefore, when approaching self-care in psychosocial interventions, whether through playful dynamics/resources, in a psychoeducational format, or both, professionals should take into account the role of gender and social impositions that fall on individuals at a given historical moment- social, in order to be careful with – avoiding as much as possible – biased, unilateral, reductionist perspectives of the facts, and, above all, contextualizing your approach to the reality of that individual (Barbosa et al., 2017).

Also, regarding the application of the content, the participants reported having used optimism in reevaluating/giving a new perspective to events in their lives: "I became more attentive to observing the good things in my life and valuing them more" (A.V. 56 years old, Group5 -afternoon); "Maybe I learned to see life more positively" (M. 67 years old, Group3-afternoon). In this sense, a parallel can be drawn between processing information more optimistically and the role of positive emotions promoted in groups (in addition to the technical knowledge provided in the sessions). This is because positive emotions facilitate the global processing of information, resulting in greater cognitive flexibility and association of ideas for developing different coping and problem-solving strategies (Kiken & Fredrickson, 2017). In this case, from the experience of positive emotions (interest, curiosity, positive affect, gratitude, forgiveness, etc.), participants find it easier to develop/practice a broader information processing model, interpreting situations from different perspectives, and not just through a negative view of a problem/difficulty. Therefore, the combination of program elements (multicomponent aspects) may have facilitated gains in health, notably optimism, according to the reports obtained.

Furthermore, 11 participants reported that the content covered in the program contributed to their forgiveness/self-forgiveness and gratitude processes: "As for forgiveness, it was essential for self-forgiveness of a situation that held back my life" (B. 59 years old, Group2-morning); "I thought the gratitude approach was excellent. I remembered very happily how grateful I was to my husband" (M. 67 years old, Group2-afternoon); "Every day I make a list of the three good things that happened to me that day" (N.65 years old, Group6-afternoon). Considering how these variables can contribute to a better state of health – with forgiveness being related to the reduction of depressogenic and anxiogenic symptoms and gratitude being related to greater optimism, coping, and overcoming adversities, among others (Bolier et al., 2013; Kiken, & Fredrickson, 2017) – the potential for gains from interventions that aim to work on these forces is evident since participants were mobilized regarding these aspects.

Interestingly, results regarding the use of 'self-care' variables followed by reports of improved 'self-esteem' increased in T3. In other words, over time, more participants reported using self-care resources/techniques/practices. Based on the debates and themes of the program, there may have been greater awareness about the need to value oneself and care for life/health, which resulted in greater self-care by the participants over time. Consequently, this mobilization may have helped to increase self-esteem for some participants, as reported elsewhere (Tamayo et al., 2001). Self-esteem is one of the central components in the constitution of individuals' self-concept. In other words, it concerns the evaluative component of oneself and the perception of one's self-worth. This demonstrates the positive spiral effect, in a logical sequence, where the development of an aspect of life, in this case, strengths worked on in the program (prudence/self-care), tend to have repercussions on different types of health, both physical and emotional/mental. Therefore, the practical application of some content over time (T2=77.7% and T3=87.2%) and its maintenance were considered satisfactory in this study. As a hypothesis of the increase identified in the results over time, there is the possibility of more time to prepare the content covered in the program and also time to use the content in participants' daily life situations.

It is worth remembering that recent recommendations from the World Health Organization (WHO, 2015) have emphasized the promotion and maintenance of the health of individuals and communities and investment by countries in public policies and practices that favor active aging in the long term. This presupposes the implementation of health programs on the development or improvement of skills for greater independence, autonomy, social participation, and quality of life as people age. This perspective expands the scope of action in health, to include the adoption of health policies and programs with proposals that encourage the flourishing of potential for self-care – taking responsibility for health determinants – and establishing healthy and active aging.

Our results indicate general improvements in the participants' health, similar to data from a meta-analysis study (Sin & Lyubomirsky, 2009), on the direct and indirect effects of Positive Psychological Interventions (PPIs), to improve depressive symptoms and general health. In the present study, more than 30% of the sample had previously received a diagnosis of psychopathology, mainly related to mood disorders, anxiety disorders, and sleep dysfunction. It is possible to argue that the perception of improvement reported by participants after the intervention, and maintenance three months after completion, as well as the practical usefulness of the content provided, illustrate the therapeutic potential of the program, in addition to health promotion.

Final considerations

Taking into account the qualitative and quantitative assessments of the Vem Ser Program, there were positive results in terms of participant's satisfaction with the program (clarity and understanding of content, learning from the program, session times) and with the moderator. On the other hand, the least positively evaluated aspect concerns the duration of the sessions and the program as a whole, based on objective data and suggestions from participants to expand the program. Regarding the application of the contents, through qualitative and quantitative data, we observed the use of the content provided/worked on in the program in the 'real life' of the participants continued after the end of the program and three months after completion of the sessions. The convergence of qualitative and quantitative data from participants favored greater robustness for the accuracy of the analyses in this study, as suggested in the scientific literature for evaluating

interventions (Levitt et al., 2018). Verifying the adequacy of the intervention proposal, from the perspective of the participants, contributes to the social validation of the intervention, observing whether the proposed objectives are valid and whether the effects are important, as proposed by Barbosa and Murta (2019).

The data from the present study demonstrate that this intervention model – based on Positive Psychology and CBT – can complement/favor health promotion strategies, expanding the understanding of health beyond avoiding/preventing diseases, but as a continuous movement to promote the strengths/virtues of individuals. Based on the participants' considerations, this type of intervention tends to influence practical mobilizations favoring greater self-care, and consequently, with repercussions on the individual's health and their relational context. Thus, the proposed intervention model, based on strategies for developing strengths/potentialities from a positive perspective, has special value for preventive work with vulnerable populations, such as groups of retirees, in the search for active and healthy aging.

Therefore, interventions such as the one proposed in this study are suggested to be continued, with replications in new groups, in different contexts, and in distinct samples in the country, seeking to broadly assess their applicability. Future studies should include screening more specific clinical cases and, whenever possible, promoting subgroup analyses, for example, considering participants' socioeconomic status to understand the profile of users who tend to benefit most from this type of intervention.

A limitation of this study is the non-inclusion of a measure to assess social desirability. Nevertheless, methodological rigor was assessed by ensuring anonymous evaluation in T2 and T3 for the free expression of participants regarding their perceptions, suggestions, and criticisms of the program and criteria evaluated in this study. There was an effort to reduce evaluation bias by including a mixed method and self-report by participants, preserving the anonymity of the evaluations and data obtained. However, it is impossible to generalize the results to a broader national context, given the specificities of the sample (such as a higher educational level than the average of the retired population), the small size, and the non-random nature of the sample, as described in this study.

Future studies should consider intervention groups in community spaces (Primary Care, community centers, etc.) to encourage the participation of low-income individuals/in greater socioeconomic vulnerability and include a larger proportion of the population, which remains a limitation of the present study. The importance of including the implementation and evaluation of programs aimed at the aging population in public health policies, especially in vulnerable situations, is also highlighted, as this is a major challenge in the new sociodemographic configuration of countries. Preventive interventions, or those with a health promotion nature with a positive focus, can contribute to improving the quality of life and defending the social rights of this population.

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